[Annals of Health Law](http://lawecommons.luc.edu/annals)

Volume 6
Issue 1 *1997*

Article 3

1997

Interpreting the 1996 Federal Antitrust Guidelines for Physician Joint Venture Networks

Edward Hirshfeld
American Medical Association

Follow this and additional works at: http://lawecommons.luc.edu/annals

Part of the Health Law and Policy Commons

Recommended Citation
Edward Hirshfeld *Interpreting the 1996 Federal Antitrust Guidelines for Physician Joint Venture Networks*, 6 Annals Health L. 1 (1997).
Available at: http://lawecommons.luc.edu/annals/vol6/iss1/3

This Article is brought to you for free and open access by LAW eCommons. It has been accepted for inclusion in Annals of Health Law by an authorized administrator of LAW eCommons. For more information, please contact law-library@luc.edu.

Interpreting the 1996 Federal Antitrust Guidelines for Physician Joint Venture Networks

*Edward Hirshfeld**

INTRODUCTION

The *Statements of Antitrust Enforcement Policy in Health Care* ("Statements")[1] issued by the Federal Trade Commission ("FTC") and the United States Department of Justice ("DOJ")[2] on August 28, 1996, made dramatic changes in how these agencies evaluate the legality of physician joint venture networks under federal antitrust laws.[3] These changes are important to

* Mr. Hirshfeld is vice president and associate general counsel of the American Medical Association. He received his Bachelor of Arts from Harvard University, and his Juris Doctor and Master of Business Administration from Cornell University. Prior to serving the AMA, he was a partner with Gardner, Carton & Douglas in Chicago, Illinois.

The author gratefully thanks Sanja Sharma, J.D., from Loyola University Chicago School of Law for his assistance with research for this article.

1. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996) [hereinafter STATEMENTS] (consisting of nine Statements that address different subject areas). This article will refer to individual Statements by number, for example, "Statement Eight," and will cite to pages in the officially released version. The Statements can be found at the DOJ web sites, gopher@justice.usdoj.gov or http://www.usdoj.gov; the FTC web site is at http://www.ftc.gov.

2. The FTC and DOJ will be referred to collectively as "the agencies."

3. The changes were made to the STATEMENTS OF ENFORCEMENT POLICY AND ANALYTICAL PRINCIPLES RELATING TO HEALTH CARE AND ANTITRUST, issued by the DOJ and FTC on September 27, 1994 (the "1994 Statements"). The 1994 version revised the STATEMENTS OF ANTITRUST ENFORCEMENT POLICY FOR THE HEALTH CARE AREAS, issued in September, 1993 (the "1993 Statements"). Page citations will be to the officially released versions of these documents.

The Statements are enforcement policies only and not laws. While courts are not obligated to follow them, they usually regard the enforcement policies of the DOJ and FTC as persuasive authority and often do follow them. In addition, the Statements are regarded as authoritative by the health care industry due to the absence of case law on the subjects addressed in the Statements and due to the threat of enforcement actions by the agencies if a physician joint venture network transgresses the Statements. Both agencies have very active enforcement programs for the health care industry. For a summary of these actions, see Gail Kursh, Chief, Health Care Task Force, U.S. Dep't of Justice, Update on Antitrust Division Health Care Enforcement Activities, Address Before the National Health Law. Ass'n (Feb. 13, 1997) *in* NATIONAL HEALTH LAW. ASS'N, ANTITRUST IN THE HEALTHCARE FIELD (1997), and Robert F. Leibenluft, Assistant Director, Bureau of Competition, Federal Trade

Annals of Health Law, Vol. 6 [1997], Iss. 1, Art. 3

the medical profession because they remove antitrust enforcement policies that were barriers to the formation of physician joint venture networks ("networks").[4]

Network formation is important to physicians as a strategy for adapting to managed care. A network enables physicians to offer to managed care health plans[5] a package of high-quality medical services in a defined geographic area at a competitive cost. Health plans are often willing to work with networks because networks can assume some of the plan's functions, such as recruiting physicians and managing medical care.[6] By assuming these functions, network physicians can have greater control over patient care, which is important to a physician's sense of professional mission. In addition, health plans will want to contract with networks that perform these functions well, allowing the network physicians to prosper economically.

The nine Statements facilitate network development in two ways. First, they provide specific criteria for certain types of networks considered to be legal. Networks that meet these criteria fall within an "antitrust safety zone"—the agencies will not investigate or challenge the legality of these networks except in extraordinary circumstances. Physicians organizing networks that fall within these antitrust safety zones can be confident that they will not be challenged by the agencies.[7]

Comm'n, FTC Antitrust Actions in Health Care Services (Jan. 1997) (on file with the author). The 1993 and 1994 Statements were widely regarded as authoritative and had a major impact on the decisions of physicians and their attorneys in network formation.

4. The Statements define a network as an independent practice association ("IPA"), a preferred provider organization ("PPO"), or a substantively equivalent arrangement that is designed to market the services of the participating physicians to health plans. STATEMENTS, *supra* note 1, at 61 n.22, 62, 106. When physicians participate in networks, they typically continue to compete with each other for patients who are not enrolled in the network. This distinguishes the network from a fully integrated group practice, where the physicians are partners, shareholders, or employees, and do not compete with each other.

5. In this article, "health plan" refers to a broad range of payers, including health maintenance organizations, preferred provider organizations, point-of-service plans, traditional indemnity health insurance plans, self-funded employer plans, and others.

6. Assumption of these functions by networks is particularly useful to payers who do not want to invest in them (such as self-funded employers) or who are trying to enter a new market and need to recruit highly regarded physicians while minimizing the cost of assembling a physician network.

7. The agencies say they will not challenge networks that fall within the safety zones "absent extraordinary circumstances." STATEMENTS, *supra* note 1, at 64-65. While to date the agencies have not challenged a network that was in a safety zone, they have disagreed with parties about whether a proposed network would be in a safety zone. For example, in one business review letter, the DOJ disagreed with phy-

Second, the Statements say that many networks outside the safety zones are likely to be legal, although they do not provide specific criteria by which these networks can be identified. Instead, such networks are subject to agency review to determine whether they are legal; the Statements describe the review process and the factors considered in reaching a decision about the legality of a network. This review process is deliberately flexible, as the agencies are not confident that they can describe the exact characteristics of every type of network that is legal or illegal, and, given the many network variations, the agencies do not want to chill the development of networks that would be beneficial to the market, nor allow networks that are anticompetitive.

Because of the lack of specificity in the Statements about when networks outside the safety zones are legal, evaluating the legality of such a network requires the exercise of judgment. Now that physicians and their attorneys have been working with the Statements for almost one year, questions have arisen about how to interpret key aspects of the Statements in order to make these judgments. It is important that these questions be addressed, because uncertainty can chill efforts to organize networks.

Interpreting the Statements and making judgments with confidence requires familiarity with the fundamental antitrust principles underlying the Statements, and familiarity with how the agencies are applying these principles in the Statements. Part I of this article will summarize the fundamental principles of federal antitrust law through an analysis of joint ventures under the antitrust laws. Part II will then explain how the Statements apply these principles. Finally, part III will specifically address the major questions of interpretation that are being raised.

In summary, part III will answer four questions. First, is there an availability of simple networks? Many physicians think that the Statements make network development impractical, believing that the Statements require sophisticated networks where the physicians assume risk, such as capitation arrangements, or, if on a fee-for-service basis, require that the physicians be highly

sicians that their proposed network would be in a safety zone, warning that the network might violate the antitrust laws if it was formed. Letter from Anne K. Bingaman, Assistant Attorney Gen., Antitrust Div., Dep't of Justice, to Tad R. Callister, Callister & Callister, Glendale, Cal., concerning the Orange Los Angeles Medical Group (Mar. 8, 1996).

integrated. Many physicians feel that such networks require a degree of investment, expertise, time, and political consensus that they cannot muster. However, the Statements allow the formation of a "messenger model" network that requires only a modest investment, is simple to operate, does not cause political tension within a physician community, can accomplish many of the functions that are needed from a network, and is available to most physician communities.[8]

Second, what constitutes clinical integration? Statement Eight allows fee-for-service networks[9] to operate where the participating physicians agree on the fees that they will charge through the network. However, if such networks are not clinically integrated, their price agreement will be viewed as price fixing, which is per se illegal.[10] The Statement offers some guidance on what constitutes clinical integration, but not enough to convey a solid understanding of the concept. While some attorneys argue that a multimillion dollar investment in a management infrastructure, such as computer-based medical information systems, is necessary to achieve clinical integration, these investments are not required to achieve clinical integration, and this type of network is within the grasp of many physician communities.

Third, what percentage of a specialty market can join the network? The agencies are interested in the percentage of physicians within a particular specialty who make up the network. Statement Eight creates an antitrust safety zone for networks that meet certain specialty concentration percentages, as well as other criteria.[11] The Statement emphasizes that networks with

8. The messenger model is described in Statement Nine, STATEMENTS, *supra* note 1, at 125-27, and hypotheticals applying this model follow Statement Nine, *id.* at 138-40, and follow Statement Eight, *id.* at 102-05.

9. It is important to distinguish between the way a network is paid by a health plan, and the way the network pays the participating physicians. For example, a network that takes capitation may pay some or all of its participating physicians on a fee-for-service basis. STATEMENTS, *supra* note 1, at 69-70 n.33. *In Hassan v. Independent Practice Assocs., Inc.*, 698 F. Supp. 679 (E.D. Mich. 1988), the court found a network that took capitation from a health maintenance organization and paid its physicians pursuant to a fee-withholding arrangement to be legal.

10. The Statements allow networks that use certain managerial techniques to enhance quality and reduce costs other than risk sharing to be evaluated by the rule of reason. STATEMENTS, *supra* note 1, at 72-73. While the text of the Statements does not refer to these activities as constituting clinical integration, Hypothetical One at the end of Statement Eight and Hypothetical One at the end of Statement Nine use the term in their titles, and antitrust attorneys have begun using that term.

11. *Id.* at 64-70.

greater concentrations than the limits will be reviewed under the rule of reason and can be legal,[12] and provides some guidance about the conditions under which the agencies will consider these networks to be lawful.[13] However, the Statement's guidance is not clear, thereby leaving uncertainty for larger networks.

Fourth, are there any opportunities for direct contracting? Before the Statements were issued, networks that wanted to directly contract with self-funded employers[14] found themselves caught between the demands of two sets of laws. If they wanted to contract on a fee-for-service basis, they would likely be engaged in price fixing in violation of the federal antitrust laws. If they avoided this by entering into capitation arrangements, they could be subject to state insurance regulation.[15] The Statements have resolved this problem in two ways. First, they allow fee-for-service networks with clinical integration[16] to be formed, which enables fee-for-service direct contracting arrangements. Second, they create a new category of substantial financial risk. There has been uncertainty over the meaning and purpose of this category of substantial financial risk. It allows a network to contract with a self-funded employer on a fee-for-service basis

12. *Id.* at 63, 77-78.

13. *Id.; see also* the hypotheticals, *id.* at 83-105.

14. Self-funded employers do not purchase health insurance for their employees. They pay for the health care expenses of their employees as they arise. However, they often hire insurance companies or entrepreneurs known as "third-party administrators" to administrate their health benefit plans. These arrangements often appear to be insured benefits plans to the employees and the providers who treat them. The benefits plan of a self-funded employer is exempt from state regulation under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144 (1994) ("ERISA"). It is estimated that over 50% of employed Americans receive their health coverage from an exempt, self-funded plan. American Med. Ass'n, *Direct Contracting With Employers: A Strategy to Increase Physician Involvement in the Current Health Care Market, in* House of Delegates Proceedings, 144th Annual Meeting 28 (June 18-22, 1995) (on file with the author).

15. The extent to which self-funded plans are exempt from state laws is a continuing source of controversy. Particularly controversial is whether ERISA exempts risk-sharing arrangements between self-funded plans and providers. Most insurers, most state insurance commissioners, and the National Association of Insurance Commissioners ("NAIC") argue that ERISA does not exempt such arrangements because they amount to the transfer of risk and the spreading and sharing of risk, and therefore constitute the sale and purchase of insurance. For the NAIC position, see the comments of Kenney Shipley, Chair of the Health Plan Accountability Working Group, *in Insurance Regulation: NAIC Bulletin to Address Application of Insurance Laws to Provider Groups*, 3 BNA's Health Care Pol'y Rep. 32 (Aug. 7, 1995). For an overview of this controversy, see Allison Overbay & Mark Hall, *Insurance Regulation of Providers That Bear Risk*, 22 Am. J. L. & Med. 361 (1996).

16. *See supra*, note 10.

and to be eligible for a reward if it meets budgetary goals, enabling a network to realize many of the benefits of full-risk or global capitation;[17] since it is not subject to downside risk, it need not acquire an insurance license. Further, a network using this technique can qualify for a safety zone if it falls within safety zone specialty concentration limits.

The Statements provide physicians with opportunities to create networks otherwise subject to review. However, they also create new questions, which in time, hopefully, will be clarified.

I. ANALYSIS OF JOINT VENTURES UNDER THE ANTITRUST LAWS

A network is a form of a joint venture. To understand the 1996 guidelines, it is best to have some familiarity with how joint ventures are evaluated for legality under the antitrust laws.

A. *Standards for Proof of Conduct that Violates the Antitrust Laws*

Antitrust laws are meant to preserve competition in a market. They regulate cooperative activities among participants in a market to preserve and enhance competition. Some types of cooperative activities violate the antitrust laws because they harm competition, while other types are not violative because they enhance or do not harm competition. Joint ventures are a type of cooperative activity that could either enhance or harm competition. The antitrust laws distinguish between cooperative activi-

17. Full-risk capitation is the assumption of risk by primary care physicians for all physician services, including those which they cannot directly deliver. The primary care physicians must contract with other specialist physicians for those services that they cannot deliver; they profit if the amount that they receive in capitation for the services involved is greater than the amount that they have to pay the other specialist physicians for the services involved. PETER BOLAND, THE CAPITATION SOURCEBOOK 107 (1996); *see also* Frances H. Miller, *Capitation and Physician Autonomy: Master of the Universe or Just Another Prisoner's Dilemma (What Can Britain's National Health Service Experience Teach Us?)*, 6 HEALTH MATRIX 89, 92-95 (1996). Global capitation exists when a network takes risk for most, if not all, of the benefits package. For example, a physician network is engaged in global capitation when it assumes risk for hospital services as well as physician services. BOLAND, *supra* at 113. If it costs the network less than the capitation amount to arrange for hospital services, the network profits. Full-risk and global capitation give the capitated provider an incentive to minimize the use of services of the other providers for which it assumes risk. Typically, the providers given full-risk or global capitation are in a position to manage the use of those services. For example, primary care physicians can control referrals to specialists, and specialists control many of the hospital admissions and services provided within the hospital.

ties, including joint ventures, that enhance competition and are legal, and those that are illegal because they harm competition.

Cooperative arrangements among competitors or among other participants in a market that unreasonably restrain competition are illegal. Restraints are unreasonable if they have a material adverse effect on competition in a market. Most restraints are evaluated in light of two tests, illegal per se and rule of reason. First, certain cooperative arrangements are always illegal (illegal per se) regardless of whether there is proof that the offense actually had an adverse impact on competition in the market involved. This kind of conduct is considered to be so threatening to competition that it is automatically illegal. A violation is shown by the fact of the conduct—nothing more needs to be proven to declare it illegal. Second, cooperative arrangements that are not illegal per se are evaluated for legality under the rule of reason. Such arrangements are not automatically deemed illegal. The object of the rule of reason analysis is to determine whether the arrangement in fact had or is likely to have a material adverse effect on competition in the market.[18] Therefore, proving the fact of the cooperative arrangement is not enough to prove a violation. All relevant factors in the market are reviewed to determine whether the restraint is, on balance, materially anticompetitive.

Antitrust offenses especially relevant to network formation include price fixing, a group boycott or concerted refusal to deal, and a division of markets.

Price fixing occurs when two or more independent competitors in a market agree about the prices that each will charge to third parties. When a group of independent, competing physicians agrees on the fees that they will charge to a health plan, they engage in price fixing. This offense is illegal per se.[19]

A group boycott or concerted refusal to deal is an agreement between two or more independent competitors not to deal with a third party. It can also be an agreement between an independent buyer and a seller not to deal with a third party. Some group boycotts are illegal per se, especially those that are designed to support a price-fixing agreement or keep firms out

18. The rule of reason is a structured process used to make that evaluation. It requires the agency or court to define the product and geographic market, evaluate the purpose of the restraint, evaluate its effects on competition in the market involved, and determine whether there are any procompetitive efficiencies that outweigh its adverse effects on competition.

19. Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982).

of a market. For example, an agreement among independent competing physicians to boycott HMOs that do not accept their agreed-upon fee schedule or to boycott HMOs altogether to keep them out of the market is per se illegal. Other types of boycotts are examined under the rule of reason.

A division of markets is an agreement among competitors in a market dividing the market into segments and agreeing that they will not compete outside their respective segments; the agreement is illegal per se. For example, if the physicians on the east side of town agree with the physicians on the west side of town that the east siders will not accept patients from the west side and vice versa, they have created an illegal horizontal division of markets.

B. *Exceptions to the Per Se Illegal Analysis*

Federal case law has established an exception to the rule that price fixing, division of markets, and certain group boycotts are illegal per se,[20] allowing a joint venture to be evaluated under the rule of reason to determine its actual effect on competition. The rule of reason is used to evaluate the conduct because the efficiencies of the cooperative activity may benefit consumers more than the detriments caused by the reduced competition will harm consumers.

---

20. The Supreme Court has applied the rule of reason to normally per se illegal restraints when it found joint ventures that created essentially a new product or established new efficiencies through integration. Broadcast Music, Inc. v. Columbia Broadcasting Sys., 441 U.S. 1, 21-23 (1979). Most importantly, the Court has noted that not all joint ventures that have an impact on price are per se violations of the Sherman Act. *Id.* at 23. The Court has also realized that certain industries require horizontal restraints in order to produce a particular product. National Collegiate Athletic Ass'n v. Board of Regents of Univ. of Okla., 468 U.S. 85, 100 (1984). Additionally, the Court has recognized that it cannot always describe the types of business activities that should automatically fall into the forbidden per se category. Northwest Wholesaler Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284, 294 (1985). Finally, the Court expressed its unwillingness to adhere to a rigid per se analysis where the economic impact of particular activities is not immediately clear. Federal Trade Comm'n v. Indiana Fed'n of Dentists, 476 U.S. 447, 459 (1986).

Many appellate court decisions have supported the Court's reluctance to adhere to a summary condemnation of certain business practices. *See, e.g.*, Polk Bros., Inc. v. Forest City Enters., Inc., 776 F.2d 185 (7th Cir. 1985); National Bancard Corp. (NaBanco) v. VISA U.S.A., Inc., 779 F.2d 592 (11th Cir.), *cert. denied*, 479 U.S. 923 (1986); Rothery Storage & Van Co. v. Atlas Van Lines, Inc., 792 F.2d 210 (D.C. Cir. 1986), *cert. denied*, 479 U.S. 1033 (1987). These courts had found efficiencies through integration as well as other procompetitive benefits resulting from an agreement or collaboration among competitors that included restraints that are normally illegal per se. For an excellent summary of these cases and others, see AMERICAN MED. ASS'N, ANTITRUST LAW DEVELOPMENTS 393-428 (4th ed. 1997).

Such arrangements may be evaluated under the rule of reason when (1) the cooperating parties are generating substantial *efficiencies* that are passed on to customers in the form of lower costs and/or better quality because they have *integrated*[21] their activities, and (2) it is necessary for the cooperating parties to engage in the conduct that is ordinarily illegal to effect the integration that achieves the efficiencies.

The efficiencies must be substantial enough to outweigh the potential adverse effect on competition of the cooperative activity—the more likely it is that a cooperative activity will have an adverse effect on competition, the greater the showing of efficiencies must be. While the key to demonstrating efficiencies is measuring the quantity of efficiencies that will be produced, it is very difficult to measure the extent of efficiencies, especially if a joint venture is being formed and is not yet in operation. Therefore, in the absence of measured efficiencies, the agencies will look for characteristics in a joint venture that are likely to result in the generation of efficiencies. Since efficiencies are generally assumed to result from the integration of the cooperating parties, proving the extent of the efficiencies (and that cooperation among the parties is necessary to achieve them) is often done by proving the extent of integration involved.

Persons who sufficiently integrate their business activities are considered to be a part of one business entity and are allowed to engage in cooperative activities that are denied to independent competitors. However, the antitrust laws distinguish between different degrees of integration. It is more likely that efficiencies will be assumed to outweigh the anticompetitive effects of a

21. The concept of integration is a specific concept under antitrust laws. Under the antitrust laws, integration occurs when two persons have joined and coordinated their business activities for purposes of offering a product or service to purchasers in a market. The most commonly recognized integration is where two parties may make a common investment and share the opportunity for profit and the risk of loss. *Maricopa*, 457 U.S. at 356 (distinguishing a network engaged in illegal price fixing from a legitimate joint venture by saying: "The foundations are not analogous to partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit. In such joint ventures, the partnership is regarded as a single firm competing with other sellers in the market."). Courts also recognize "contract integrations," where the parties do not pool assets under common ownership but coordinate their activities in a way that produces efficiencies. *Rothery Storage*, 792 F.2d at 214; *see also* ROBERT H. BORK, THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF 264-79 (1978). The assumption that a sufficient amount of integration produces efficiencies that outweigh the anticompetitive impact is, for the most part, correct—all of the great businesses in the world today resulted from persons integrating their activities.

Annals of Health Law, Vol. 6 [1997], Iss. 1, Art. 3

joint venture, and therefore be considered legal, as the amount of integration of the participants increases. For example, the assumption that efficiencies will result is stronger when the parties pool assets than it is when they only contractually integrate.

Networks can fall within this exception if they can prove that they can achieve efficiencies, such as lower health care costs, and better quality by integrating the activities of a number of providers. In addition, they can prove that the agreements among the network participants regarding fees or capitation rates to be charged by the network are necessary to make the network function. Upon falling within the exception, the agencies will analyze the network under the rule of reason.

C. *The Antitrust Treatment of Different Levels of Integration Among Physicians*

Unintegrated groups of physicians are those who wish to engage in a cooperative activity, but who do not want to pool economic resources, share any economic risk with other physicians, or engage in a contract integration that generates substantial efficiencies. Physicians in unintegrated groups may not engage in price fixing, group boycotts that are per se illegal, or divisions of markets.

A group of independent physicians who do nothing more than agree with each other to provide services pursuant to a discounted fee schedule is considered to be unintegrated. Such an agreement can reduce transaction costs for payers who want a network of physicians willing to discount fees, because the payer need not approach and negotiate with each physician individually. These savings in transaction costs are efficiencies. However, the agencies do not believe that these efficiencies are substantial enough to justify the potential adverse effects on competition of the fee agreement among the physicians.[22] The agencies are concerned that the physicians will attempt to nego-

22. For example, the DOJ has said: "[A]n agreement among competitors to set a minimum price, for example, would not be saved from *per se* condemnation simply because the defendants claimed that the agreement eliminated the transaction costs that consumers would otherwise incur in searching out the lowest price." U.S. Dep't of Justice, Antitrust Div., *Antitrust Enforcement Guidelines for International Operations (1988), reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,109.10, at 20,594 (Apr. 11, 1995) [hereinafter *1988 International Guidelines*]. The 1988 version of these guidelines was superseded by the *Antitrust Enforcement Guidelines for International Operations (1995), reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,107 (Apr. 11, 1995) [hereinafter *1995 International Guidelines*], which does not address the issue of efficiencies; the 1988 version is still an accurate view of the DOJ on this subject.

tiate fees that are higher than would prevail in free competition, and then will back up those negotiations with a threat of boycott. Therefore, these arrangements among unintegrated physicians are per se illegal and do not qualify for rule of reason analysis.

Partially integrated groups of physicians are those who are willing to pool some economic resources and share some economic risk with other physicians, but do not want to merge their practices with other physicians. If the physicians have sufficiently integrated their activities and are generating substantial efficiencies, physicians in partially integrated groups may, under some circumstances, agree on prices that they will charge to third parties, refuse to deal with some parties, and agree on which patients each will treat. These arrangements will not be per se illegal and will be reviewed under the rule of reason. Partially integrated groups of physicians that are generating substantial efficiencies are sometimes called "legitimate joint ventures." Independent practice associations and preferred provider networks, depending on their activities, may be legitimate joint ventures.

Fully integrated groups of physicians are those who have merged their practices into one entity, such as a partnership or medical corporation. Fully integrated groups are not considered a joint venture network because the physicians are not competing with each other in independent practice. Because they have fully integrated, it is assumed that the group is generating substantial efficiencies. Physicians in fully integrated groups may decide upon the prices that they are going to charge to payers, they may refuse to deal with payers who do not accept their terms, and they may decide which physicians in the group will treat which patients.[23] Physicians who are employed by a corporation, such as a hospital, foundation, HMO, insurer, or other entity, are also considered to be part of a fully integrated group. Multiprovider networks, such as combinations of hospitals and

23. However, there are limits to how large a fully integrated group may grow by acquiring the practices of competing physicians. The group may not acquire a monopoly or cause a substantial increase in the concentration of ownership of physician services by merging with other physicians with practices in the market. For guidelines on how large a firm can grow by merging with other firms, see U.S. Dep't of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines, reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,104 (Apr. 2, 1992) (amended Apr. 8, 1997). A physician group may grow by bringing in additional physicians from outside of the market.

physicians, may also be fully integrated if they are all merged into a single entity or are under common control.

D. *Proving Sufficient Integration and Efficiencies to Qualify for Rule of Reason Analysis*

In summary, the application of the antitrust laws to unintegrated and fully integrated groups of physicians is very clear. The problem for physicians and their attorneys is knowing when a partially integrated group, such as a network, will be deemed to have sufficient integration to generate efficiencies substantial enough to fall within the exception to the per se rules.

There is general consensus among learned commentators that federal case law does not provide sufficient guidance for joint ventures.[24] No cases have defined with precision the quantity of efficiencies that are necessary nor the extent of integration between the parties that will be deemed sufficient to meet the burden of showing the existence of substantial efficiencies. Instead, the courts rely on the use of a process to evaluate whether the efficiencies made possible by the restraints involved in the joint venture enhance competition more than they harm competition. This is a flexible process—it does not place arbitrary thresholds on the amount of efficiencies or integration that must be present nor does it define a maximum amount of efficiencies beyond which a partially integrated joint venture is clearly legal. Instead, the amount of integration and efficiencies are evaluated together with all other relevant characteristics of the joint venture that might affect competition, such as the market power of the venture, together with the nature of competition in the market.

The nature of this process has become confusing because of controversy over how it should be articulated. It is apparent, as a practical reality, that the process must have at least two steps. First, the court must decide whether the restraint involved in the

24. Most critics agree that antitrust case law fails to provide clear guidance for attorneys and businesses as to what is permissible under the law. *See, e.g.*, Thomas A. Piraino, Jr., *Reconciling Competition and Cooperation: A New Antitrust Standard for Joint Ventures*, 35 WM. & MARY L. REV. 871, 878 (1994); Thomas A. Piraino, Jr., *Beyond Per Se, Rule of Reason or Merger Analysis: A New Antitrust Standard for Joint Ventures*, 76 MINN. L. REV. 1, 12 (1991); Robert Pitofsky, *A Framework for Antitrust Analysis of Joint Ventures*, 74 GEO. L. J. 1065 (1986) (Mr. Pitofsky is currently the FTC Chairman); James T. Halverson, *The Future of Horizontal Restraints Analysis*, 57 ANTITRUST L.J. 33 (1988).

joint venture that would ordinarily be deemed per se illegal should be evaluated under the rule of reason, using the test articulated above. Second, if the court does not declare the joint venture illegal per se, it must apply the rule of reason and evaluate the extent of measurable efficiencies or integration involved. As a practical matter, the two steps tend to run together. Determining whether to evaluate a restraint that is normally illegal per se under the rule of reason requires some inquiry into whether the rationale for the exception from per se treatment is present, in other words, whether the restraint enables the joint venture to generate efficiencies. This inquiry resembles the rule of reason analysis itself.

This practical reality worries antitrust law enforcement officials and supporters of strict enforcement of the antitrust laws because it appears to eliminate rules of per se illegality. The premise of these rules is that certain trade restraints are so inherently anticompetitive that there is no need to inquire into their effect on competition. Once these restraints are examined to consider their overall effects on competition, then the premise of per se illegality is lost. Antitrust enforcement officials want to preserve the strength of the per se rule as much as possible. Other commentators want the antitrust laws to be flexible enough to accommodate legitimate joint ventures, as they have brought and are likely to continue to bring many benefits to consumers.[25] The result has been controversy over how to structure the inquiry to determine if the exception to per se illegality for legitimate joint ventures should apply.

Some commentators feel that federal courts have addressed this problem by creating an intermediate standard between the per se rule and the rule of reason, known as the "quick look" rule of reason test.[26] They claim that this test is for restraints that have the characteristics of per se illegal offenses, but which are not clearly without justification due to extenuating circumstances. As a result, the restraints are not summarily condemned under the test as being per se illegal; instead the court takes a "quick look" at the activity to see if the restraint is justified. The quick look may reveal that the practice is not justified,

25. BORK, *supra* note 21; Clark C. Havighurst, *Are the Antitrust Agencies Overregulating Physician Networks?* 8 LOY. CONSUMER L. REP. 78 (1995-96); Letter from Clark C. Havighurst to Henry J. Hyde, Chairman, House Comm. on the Judiciary (Mar. 8, 1996) (on file with the author).

26. *See, e.g.*, WILLIAM C. HOLMES, ANTITRUST LAW HANDBOOK 227-28, 272-87 (1997).

Annals of Health Law, Vol. 6 [1997], Iss. 1, Art. 3

in which case it is declared illegal.[27] The quick look might also reveal that the practice is clearly procompetitive, in which case it could be found legal. However, what is not clear is what happens if a quick look is taken and it is not clear whether the restraint is justified, thereby requiring a full-blown rule of reason analysis. The quick look "test" then becomes a screen to determine whether a restraint that is normally per se illegal is clearly justified or whether a full review of the restraint needs to be made to determine its legality. Such a clearly defined procedure has not been set forth by federal courts. It is not yet clear whether the quick look test actually exists and, if it does, whether it is really only a screen.

As a result of this controversy, both the DOJ and the FTC have changed their general approaches for evaluating the legality of joint ventures in recent years. Initially, the agencies set forth a procedure to screen restraints that are normally per se illegal from those that should be evaluated under the rule of reason. Subsequently, they both retreated from that approach, apparently to strengthen the concept of per se illegality. Thus, in 1988, the DOJ stated[28] that it would review joint ventures under a rule of reason analysis because the agency felt that joint ventures "typically achieve integrative efficiencies."[29] A joint venture was defined as "any collaborative effort among firms, short of a merger, with respect to [research and development], production, distribution, and/or the marketing of products or services."[30] In the same statement, the DOJ described the steps in the rule of reason process.[31]

27. The Supreme Court may have used such a quick look test to find a group boycott to be illegal in *Federal Trade Comm'n v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986). In that case an association of dentists boycotted a requirement by a health plan that dentists submit x-rays together with claims for payments to substantiate the necessity of the procedures performed. The Supreme Court did not find the boycott illegal per se; instead, it evaluated the boycott under the rule of reason, but found the boycott to be illegal without a full-blown rule of reason analysis. The Court felt that the restraint could be condemned without such a procedure.

28. *1988 International Guidelines*, *supra* note 22.

29. *Id.* at ¶ 13,109.10, § 3.4.

30. *Id.*

31. First, the DOJ looked for any anticompetitive effect(s) in the joint venture market. Second, it looked for any anticompetitive effect(s) in any "spillover markets." Next, it looked at the likely competitive effects of any nonprice vertical restraints as a result of the joint venture. If after reviewing the joint venture under these three steps, the DOJ concluded that the joint venture did not have any likely anticompetitive effects, it would not challenge it. If, however, the joint venture had significant anticompetitive effects, the DOJ would determine whether the procompe-

The DOJ withdrew this statement in 1995.[32] The current DOJ approach was articulated by Acting Assistant Attorney General Joel Klein in a speech about the analysis of horizontal restraints (joint ventures between competitors involve such restraints).[33] According to Mr. Klein, the DOJ will first determine whether the agreement is the type of restraint that is currently recognized by the courts as being a per se violation. If the agreement is not, then the Antitrust Division will look at any procompetitive justifications for the restraint. This statement is confusing since it does not clarify whether a restraint that is normally per se illegal will be evaluated under the rule of reason if it is a necessary part of the operations of a legitimate joint venture. Obviously it will, since the Supreme Court has recognized that the rule of reason will be used to evaluate such restraints.[34] The DOJ is simply protecting the status of per se rules by refraining from clarifying when the restraints involved may be reviewed under the rule of reason.

Mr. Klein stated that the parties to the agreement will have the burden of producing either factual or expert (or even both) evidence of procompetitive justifications. If the proffered justifications are unsubstantiated, then the agreement will be declared illegal. If the Division finds significant procompetitive benefits, then the Division will determine whether the agreement's likely anticompetitive effects outweigh its procompetitive benefits. Mr. Klein noted that this type of analysis usually requires an elaborate market analysis unless there is convincing evidence of direct market effect on price or output. Finally, Mr. Klein pointed out that there is a need to show real procompetitive benefits only if there are actual anticompetitive effects.[35]

The FTC's change in its analysis of joint ventures may also have been an attempt to protect the per se rules. In its 1988

titive efficiencies attempted by the joint venture outweighed its anticompetitive effects. *Id.* at § 3.41.

32. When the DOJ withdrew this statement, it updated the International Guidelines. *1995 International Guidelines, supra* note 22. The update is silent with regard to the DOJ's analysis of joint ventures.

33. Joel Klein, Acting Assistant Attorney Gen. for Antitrust, U.S. Dep't of Justice, A Stepwise Approach to Antitrust Review of Horizontal Agreements 6, Address Before the American Bar Ass'n Antitrust Section Semi-Annual Fall Policy Program (Nov. 7, 1996).

34. *See supra* note 20.

35. Klein, *supra* note 33, at 7-8.

opinion in *Massachusetts Board of Registration in Optometry*,[36] the FTC reviewed Supreme Court decisions and noted that there is no bright line between the per se and rule of reason analyses. It pointed out that the real inquiry is the same under both tests: "[W]hether or not the challenged restraint enhances competition."[37] Ignoring any distinction between the tests, the FTC established a "structure" or "decision tree" for horizontal restraint analysis.

Under the *Massachusetts Board* structure, the FTC would first ask whether the restraint was inherently suspect, meaning obviously anticompetitive. If so, then the FTC would declare it illegal without further factual inquiry. If the restraint was not inherently suspect, then the FTC would employ the traditional rule of reason analysis. If, however, the restraint was inherently suspect, the FTC would look for a plausible efficiency justification for the practice. If the justification was not plausible, then the practice would be condemned. If plausible, the FTC would see if the justification was truly valid. Once the Commission found the justification valid, the restraint would be examined under the rule of reason. If, however, the justification is found to be invalid, then the restraint is declared unlawful without further inquiry.[38]

The FTC may have modified this "decision tree" in *California Dental Association*,[39] where it said that the Supreme Court had not abandoned the traditional analysis of horizontal restraints, meaning the use of per se rules and rule of reason analyses. The FTC acknowledged the distinction between the per se and rule of reason analyses and the importance of utilizing one of the tests.[40] Consequently, the FTC used the traditional per se rule to find a restraint illegal. However, regardless of the terminology used, the description of the process in *Massachusetts Board of Optometry* may be a good summary of how the FTC analyzes joint ventures if the words "per se illegal" are substituted for "inherently suspect."[41]

36. [1983-1987 FTC Complaints and Orders Transfer Binder] Trade Reg. Rep. (CCH) ¶ 22,269, at 23,111 (Complaint, Dkt. 9195, July 8, 1985).

37. *Id.*

38. *Id.*

39. California Dental Ass'n, 5 Trade Reg. Rep. (CCH) ¶ 24,007, at 23,778 (Apr. 4, 1996).

40. *Id.* at 23,787.

41. The FTC has a task force evaluating joint venture analysis. It is expected that it will issue a report in 1997, further explaining the FTC's approach to joint ventures. *See* FTC Notice, Comment and Hearings on Joint Venture Project, 62 Fed. Reg. 2295

A way to conceptualize how the agencies and the courts review a network that uses restraints normally considered to be illegal per se, such as an agreement among the participating physicians about fees, is the following three-step analysis. First, they will consider whether the joint venture and its restraints are obviously anticompetitive. For example, they will review the network to see if it is obviously meant to gain market power over payers and fix fees at levels higher than would prevail if the physicians competed with each other for the business of payers. If the network is not obviously intended to restrain competition, the agencies will consider whether the network generates more than a minimal amount of efficiencies, considering, for example, whether the network generates only transactional efficiencies or a greater amount of efficiencies. Finally, they will consider whether the restraints involved are obviously needed to generate the claimed efficiencies.

If the network is not obviously anticompetitive and the network can plausibly claim that the restraints are necessary to generate substantial efficiencies, then the network will be more thoroughly reviewed pursuant to a rule of reason analysis to evaluate (1) whether the efficiencies are sufficient to outweigh the anticompetitive effects of the restraints, and (2) whether the restraints are truly necessary to generate the efficiencies. The greater the anticompetitive effect of the restraint, the greater the degree of efficiencies that must be shown to justify them.

As discussed above, the quantity of efficiencies is key to this analysis. However, there is controversy over what quantity of plausible efficiencies must be shown by a joint venture to qualify for rule of reason treatment, and what quantity must actually be shown to pass a rule of reason inquiry. Since the degree of integration among the participants in a joint venture is used as a way to estimate the extent of efficiencies, the controversy is often over the extent of integration necessary to qualify for and then pass a rule of reason analysis. The agencies call for a relatively strong showing of efficiencies or integration before a joint venture can qualify for a rule of reason analysis. However, one learned commentator, Professor Havighurst,[42] and at least one federal appellate court[43] would require a lower threshold.

(1997). Testimony of the hearings held by the Project are available on the FTC's website. *See supra* note 1.

42. Havighurst comment, *supra* note 25.

43. *Rothery Storage*, 792 F.2d 210.

Annals of Health Law, Vol. 6 [1997], Iss. 1, Art. 3

The argument for the lower threshold is that setting a high threshold puts the agencies and the courts in the position of regulating the merits of the products offered by joint ventures by deciding which products are good enough to allow in the market. Professor Havighurst argues that the agencies should do no more than decide whether the joint venture has a material adverse effect on competition pursuant to a rule of reason analysis, and should not be in the business of deciding the merits of the products offered by joint ventures. This, he argues, is for the market to decide.[44] The counterargument, for higher thresholds, is that low thresholds would weaken the per se rule by allowing a wide range of cooperative activity that is normally per se illegal to be evaluated under the rule of reason. At the time of this publication, the agencies continued to adhere to a high threshold in order to protect the per se rules.

E. The Rule of Reason Analysis—The Importance of Market Power

As a practical matter, since the degree of integration is a way to estimate efficiencies, showing sufficient integration to qualify for rule of reason analysis is often enough to pass the analysis itself. Once sufficient integration is shown, the key issue in a rule of reason analysis is determining whether the joint venture has market power.

When a network qualifies for rule of reason analysis, a structured review of the impact of the network on competition takes place. If a joint venture is proposed, then the agencies are concerned about the likely effect that the joint venture will have on competition in the market. If the joint venture is operating, then the agencies are concerned about the impact that the joint venture is actually having on competition in the market and the impact that it is likely to have in the future. There are substantial differences in the types of evidence available to evaluate proposed joint ventures as opposed to operating joint ventures, but the same structured review process is applied to both.

First, the product and geographic markets at issue must be defined. Then, the effect of the network on competition in the market is evaluated. With regard to a proposed joint venture, the agencies rely on the degree of market power that the joint

44. Havighurst comment, *supra* note 25.

venture will have as a reliable predictor of whether it will harm competition.

Market power is the ability of a competitor in a market to restrict output and raise prices above competitive levels. Generally only competitors with very large market shares have the power to force purchasers to accept higher than competitive prices. For example, a network that was large enough could agree to fix fees and to boycott purchasers who refuse to accept those fees. It is assumed that a partially integrated joint venture, such as a network, that can generate substantial efficiencies will do so in a competitive market where it does not have market power. It is also assumed that a joint venture that has too much market power will create an anticompetitive environment, thereby negating the benefits that consumers would reap from the efficiencies that the network can generate.

Case law fails to provide firm guidance about the permissible size of a joint venture, including a network. Generally, a single firm that constitutes less than thirty percent of the market does not have market power.[45] The agencies usually evaluate the market power of joint ventures under their *1992 Horizontal Merger Guidelines*.[46] These guidelines are concerned not only with the market power of a single firm, but the relationship of the market power of a firm with the market power of all other firms in the market. The concern is that a small number of firms that together have a great deal of market power might conspire to restrict output and raise prices. The agencies apply a formula to determine whether a merger will result in an impermissible increase in the percentage of the market. Mergers that would create a firm with a market share of less than thirty percent could transgress these guidelines if the market is already highly concentrated.[47]

The focus of market power analysis in physician and multiprovider networks tends to be on the market power of the providers combining to form the network. The issue is whether the physi-

---

45. ANTITRUST LAW DEVELOPMENTS, *supra* note 20, at 59-62.

46. U.S. Dep't of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines (1992)*, *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,104 (Apr. 2, 1992).

47. There is also a developing economic theory showing that combinations of small percentages of participants in a market result in price increases and therefore could be anticompetitive. This school of thought applies econometric analysis to predict the impact on prices of mergers or joint ventures. For a simple description of these theories, see Robert H. Lande & James Langenfeld, *The Evolution of Federal Merger Policy*, 11 ANTITRUST 5 (1997).

Annals of Health Law, Vol. 6 [1997], Iss. 1, Art. 3

cians and providers in the network could conspire to exercise market power to prevent managed care from entering the market or to raise prices above competitive levels. The agencies will review a number of factors to make this evaluation, including the percentage of physicians in the market, whether the network is exclusive[48] or nonexclusive,[49] whether there are other networks in the market, the extent of managed care penetration of the market, and the dependence of providers on managed care plans for revenues.

Market power is also an important factor when the agencies review a joint venture that is in operation. However, the actual effect of the joint venture on competition is more important. To judge the effect, the agencies will look at pricing levels, purchaser perceptions about their alternatives to the joint venture for supplies of the product involved, actual purchasing patterns, and other evidence. If this evidence tends to show that the market is not competitive, the existence of market power on the part of the joint venture may cause the agencies to conclude that the joint venture is the cause of the anticompetitive effects.

After reviewing the likely or actual effects of the joint venture on competition, the agencies will consider whether any efficiencies produced by the joint venture outweigh the harm to competition. Then the agencies will consider whether the agreements among the joint venture participants that are normally per se illegal, such as a fee agreement among the physician participants in a network, are necessary to achieve the efficiencies generated by the joint venture.

II. Analyzing Networks Under the Statements

The purpose of the Statements is to provide guidance to physicians and their attorneys about how networks will be evaluated and the positions of the agencies regarding joint ventures in general. The key information is found in Statement Eight, which is entitled "Physician Joint Venture Networks," and Statement Nine, which is entitled "Multiprovider Networks." These Statements apply to health care delivery networks owned by hospitals

48. An exclusive network is one where the physicians do not contract with other networks or health plans apart from the network. Statements, *supra* note 1, at 64. *See infra* section III(C).

49. In a nonexclusive network, the physicians remain free to contract with other networks or with health plans that do not contract with the network. *Id.* *See infra* section III(C).

and/or other providers, including physicians. Both Statements apply essentially the same principles.

The general approach used by the agencies to evaluate joint ventures provides the framework for the guidelines in Statements Eight and Nine. To summarize the discussion above, the agencies evaluate a network to see if it is inherently suspect—if it involves a price-fixing arrangement or other kind of conspiracy to restrain trade that is per se illegal with no redeeming features. If the network has plausible efficiencies,[50] especially as evidenced by sufficient integration, then it qualifies for rule of reason analysis. A high threshold is set to determine plausible efficiencies—transactional efficiencies are not sufficient to qualify a joint venture for rule of reason analysis. Then the agencies will determine if the efficiencies, especially as evidenced by the degree of integration, are substantial enough to outweigh any adverse competitive effects. The market power of the network will be evaluated to determine the likely anticompetitive effect of the network. The greater the potential anticompetitive effects, the greater the efficiencies must be, especially as evidenced by greater degrees of integration, to justify these anticompetitive effects.

However, the Statements provide more than a general framework. They provide guidance about the degree of integration necessary to qualify for rule of reason analysis as well as the extent of integration needed and degree of market power allowed to pass a rule of reason analysis. They begin by defining the characteristics of a network that will be considered sufficiently integrated with a degree of market power to qualify for and pass the rule of reason analysis. For these networks, the agencies created an antitrust safety zone.

For a network to be in the safety zone, its members must share substantial financial risk, which the agencies regard as a form of financial integration, and the physicians may not account for more than twenty percent of any specialty in the mar-

50. The agencies recently amended their Horizontal Merger Guidelines to include a revised section on efficiencies. This section is designed to provide guidance about how the achievement of efficiencies through a merger between two firms will affect the agencies' analysis of the legality of the merger. It is similar to the agencies' analysis of efficiencies in a joint venture, and is probably the most current view of how they approach the effect of efficiencies on a joint venture as well as for mergers. *Horizontal Merger Guidelines, supra* note 46, at 20,573-11 n.46. Another good description is found in the DOJ's *1988 International Guidelines, supra* note 22, at 20,594.

ket if the network is exclusive,[51] and no more than thirty percent of the market if nonexclusive. Substantial financial risk is created through arrangements whereby the venture assumes capitation,[52] receives a percentage of premium,[53] uses global fees,[54] or uses significant financial incentives to achieve specified cost containment goals, including substantial fee withholds[55] as well as penalties or rewards based on whether the network meets cost or utilization goals.

The agencies consider the assumption of financial risk to be a form of financial integration because they believe that it gives the network an incentive that assures that the network will engage in activities that give rise to efficiencies, such as better quality and/or lower costs. Those activities are not specified by the agencies, but are generally recognized in the industry to include physician credentialing to assure that their training is adequate, utilization review to prevent the provision of unnecessary care, physician profiles to teach physicians how to improve their quality and cost effectiveness, gatekeepers to control referrals, practice guidelines[56] for use by physicians in the network, and total quality improvement to consistently attain a desired medi-

51. STATEMENTS, *supra* note 1, at 64.

52. A "capitated" rate is a fixed, predetermined payment per covered life (the "capitation") from a health plan to the joint venture in exchange for the joint venture's (not merely an individual physician's) providing and guaranteeing provision of a defined set of covered services to covered individuals for a specified period, regardless of the amount of services actually provided.

Id. at 68 n.30.

53. In this arrangement, the network agrees to provide designated services to plan beneficiaries in return for a predetermined percentage of premium or revenue from the plan. *Id.* at 68.

54. Global fees involve an "agreement by the venture to provide a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors." *Id.* at 69.

55. Fee-withhold arrangements involve "withholding from all physician participants in the network a substantial amount of the compensation due to them, with distribution of that amount to the physician participants based on group performance in meeting the cost-containment goals of the network as a whole." *Id.* at 69.

56. Practice guidelines are summaries of how to treat patients with a given illness or injury with the goal of achieving the best possible outcome most efficiently. Not all practice guidelines have this objective. Some are designed for other purposes, and some do not make an effort to identify the most efficient ways to care for patients with a given problem. KIRK B. JOHNSON, ET AL., AMERICAN MED. ASS'N, LEGAL IMPLICATIONS OF PRACTICE PARAMETERS 2-6 (1990). A network wishing to use practice guidelines to qualify for rule of reason treatment should design them to achieve efficiencies.

cal outcome at the lowest possible cost.[57] The agencies are willing to assume that if a network is engaged in substantial risk sharing, it must be using these techniques and generating actual efficiencies, such as reduced cost and higher quality.

The agencies also describe the characteristics of networks that will qualify for a rule of reason analysis, but do not fall within a safety zone. These networks will not be deemed illegal per se, but will be reviewed under the rule of reason to determine if they are legal. Two types of networks are considered to qualify for the rule of reason analysis.

One type is a network that exceeds the safety zone specialty concentration limits, but is comprised of physicians who share substantial financial risk. Because the physicians in such a network have assumed substantial financial risk, the network has a plausible argument that it is demonstrating efficiencies. However, because the network's specialty concentration exceeds the safety zone limits, it will have to prove that those efficiencies will outweigh any anticompetitive effects that it may have due to its market power. While the Statements indicate that a network may be comprised of a greater percentage of specialists than the safety zone percentage limits permit,[58] they fail to identify what percentage will be permissible.

The other type of network is one not engaged in substantial risk sharing but that uses techniques to reduce costs and enhance quality that are used by risk-assuming networks (referred to as "clinical integration"[59]). For example, a network in a competitive market may want to market itself to payers who prefer to deal on a fee-for-service basis, such as preferred provider organizations and self-insured employers, and may want to get a competitive edge by using techniques to lower cost and improve quality. Statement Eight recognizes that if a network uses some or all of these techniques, it has a plausible argument that it is generating efficiencies and therefore qualifies for a rule of rea-

57. Total quality improvement ("TQI") is a set of techniques designed to reduce variation in output around a mean, with the mean being a desired outcome for the process. It was created for industrial processes, and efforts are being made to apply the concepts to health care. For a description of TQI in the industrial context, see KAORU ISHIKAWA, GUIDE TO QUALITY CONTROL (2d ed. 1986). For an application to health care, see Avedis Donabedian, *The Quality of Care: How Can It Be Assessed?*, 260 JAMA 1743 (1988); BRENT JAMES, QUALITY MANAGEMENT FOR HEALTH CARE DELIVERY (1989); PETER BOLAND, REDESIGNING HEALTH CARE DELIVERY (1996).

58. STATEMENTS, *supra* note 1, at 63, 77-79.

59. *See supra* note 10 regarding the use of this term.

son analysis. The agencies will evaluate it to determine if the efficiencies generated by the techniques outweigh any adverse effect on competition. The Statements consider a network to be "clinically integrated" if it is

> implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.[60]

While this is an example of clinical integration, it is by no means an exclusive definition. In addition, other types of integration may exist, enabling the network to prove the existence of efficiencies in other ways.[61]

Statements Eight and Nine set forth the rule of reason analysis that the agencies will apply to qualifying networks. The four-step analysis takes into account the characteristics of the network and the competitive environment in which it operates.

(1) *Define the Product and Geographic Market*: Little guidance is provided about how the market will be defined. Instead, the Statements incorporate by reference the *1992 Horizontal Merger Guidelines*,[62] which set forth substitutability as the basic test. In other words, a product market consists of services that consumers are willing to substitute for each other, and a geographic market consists of those sellers from whom consumers in a locality are willing to purchase. In both cases, a key test for substitutability is from whom purchasers would buy if the seller from whom they are ac-

60. STATEMENTS, *supra* note 1, at 72-73.

61. However, it is likely that a more substantial proof will be required to demonstrate the likelihood of such efficiencies. It will not be enough to show the integration; it will also be necessary to prove why the integration is likely to produce efficiencies since the likelihood of efficiencies will not be presumed. *See 1988 International Guidelines, supra* note 22, at 20,602 (in a rule of reason analysis, "[t]he parties bear the burden of proving such offsetting procompetitive efficiencies on the basis of clear and convincing evidence. The burden increases in direct proportion to the magnitude of the likely anticompetitive harm.").

62. *Horizontal Merger Guidelines, supra* note 46.

customed to buying increased its prices slightly but significantly.

(2) *Evaluate the Competitive Effects of the Network*: After defining the market, the agencies will evaluate whether the network could (a) raise prices above competitive levels, or (b) prevent or impede the formation of other networks or health plans. This primarily involves an assessment of market power. The agencies will also consider whether the network has taken steps to prevent spillover effects by minimizing the exchange of competitively sensitive information among the participants; they will also consider the intent of the network.

(3) *Balance the Procompetitive Efficiencies*: After evaluating competitive effects, the agencies will balance the efficiencies that will be generated by the network against any anticompetitive effects of the network to determine if the network is, on balance, procompetitive. The parties must also be able to show that the efficiencies cannot be achieved in a less anticompetitive fashion than by the formation of the network.

(4) *Evaluate Collateral Agreements*: The agencies will determine if there are anticompetitive agreements among physicians in the network that are not necessary to achieve the efficiencies. (If there are, the problem can be resolved by eliminating the agreements.)

The Statements list the following factors that indicate that a network is anticompetitive and likely to fail a rule of reason analysis:[63]

(1) statements evidencing an anticompetitive purpose;
(2) a recent record of anticompetitive behavior or collusion by the network in the market, including attempts to impede or obstruct managed care development;
(3) an obvious anticompetitive structure, such as an exclusive network with a very high percentage of local area physicians that fails to demonstrate any plausible efficiency justification;
(4) the absence of network mechanisms to generate significant efficiencies or otherwise increase competition;
(5) the existence of anticompetitive collateral agreements, such as agreements among the physicians to fix prices for those not dealing through the network; and

63. STATEMENTS, *supra* note 1, at 74; *see also* Hypothetical Three, *id.* at 89.

Annals of Health Law, Vol. 6 [1997], Iss. 1, Art. 3

(6) the absence of a means to prevent anticompetitive spillover effects.

The extent of the rule of reason analysis will vary depending on how difficult it is to decide if the venture is procompetitive or anticompetitive. The agencies can quickly conclude that the network is legal if (1) the network is one where the members share substantial financial risk or the market has a substantial amount of clinical integration, (2) the network has a small percentage of any specialty in the market, and (3) the market in which it operates is competitive. On the other hand, if a network obviously has many of the six characteristics listed above, then the agencies can quickly conclude that the network is illegal. A more in-depth, and therefore time-consuming and expensive, analysis may be needed for networks that fall between these obvious examples.

Finally, the Statements also describe a way that a physician network can be legal without sharing substantial financial risk or being clinically integrated. This type of network is designed to allow a group of physicians who want to market themselves as a group to arrive at price arrangements with a payer without agreeing on fees among themselves or agreeing in other manners that are per se illegal. Statement Nine explains this type of model, which is described more fully below.

III. Application of the Statements

A. *A Simple Network—The Messenger Model*

As stated above, many physicians feel that the Statements make network organization such a large undertaking that it is impractical. The basis for this belief is that the network has to be able to assume substantial financial risk, and therefore be able to manage risk, or have adequate clinical integration in order to fall within a safety zone or qualify for rule of reason analysis. The conventional wisdom is that such a network requires a multimillion dollar investment, employment of skilled managers, and sophistication among the physicians in managing risk.

This belief leaves physicians feeling powerless. Physicians just starting out in network organization often do not feel ready for risk sharing or clinical integration, and they feel incapable of raising millions of dollars. As a result, they are vulnerable to canards that distract them from adapting to managed care. For example, some physicians believe that joining a union empowered to engage in collective bargaining on their behalf would be

a better solution. Although that option is currently illegal for physicians in independent practice,[64] it continues to draw interest.[65]

What physicians just entering the world of managed care usually want to do is collectively market their services, which they wish to provide on a fee-for-service basis[66] (hereinafter referred to as a simple network). In other words, the efficiencies that they want to offer the market are transactional efficiencies only. In addition, they may want to include large numbers of physicians in the network to avoid tension within the medical community, which tension can result when providers are not included in a network. These physicians need to start with a simple network, adding features such as risk sharing and clinical integration as they gain experience.

There is often a market for simple networks. It is composed of payers who want discounted fees and unrestricted access to large numbers of providers. These payers want to handle utilization review functions themselves or they do not want features of managed care such as utilization review or gatekeepers. Payers with these needs are usually self-funded employers, businesses that provide administrative services to self-funded payers, such as third-party administrators, preferred provider organizations ("PPO"), or brokers that offer PPO networks to self-funded employers or third-party administrators. If physi-

64. Under the labor exemption to the antitrust laws (section 20 of the Clayton Act, 15 U.S.C. § 17 (1994)), employed physicians can unionize but are limited to collective bargaining with their employer, which is often other physicians. According to a survey by the American Medical Association, only 8.1% of nonfederally employed physicians work for health maintenance organizations. Of the rest of nonfederally employed physicians, 30.7% work for group practices or free-standing centers; 18.7% work for medical schools, universities, or colleges; 23.2% are employed by state, local, or other governments; and 16.7% work for private hospitals. CENTER FOR HEALTH POL'Y RES., AM. MED. ASS'N, PHYSICIAN MARKETPLACE STATISTICS 174 (Martin L. Gonzalez ed., 1997). Self-employed physicians in independent practice are considered independent contractors and do not qualify for the labor exemption from the antitrust laws or the protection of the National Labor Relations Act, 29 U.S.C. § 152(3) (1994) ("The term 'employee' . . . shall not include . . . any person having the status of an independent contractor . . . .").

65. The agreement of podiatrists to join the Office and Professional Employees International Union, which was announced at about the same time as the issuance of the Statements, drew as much attention and inquiry from physicians as did the Statements. *See* Steven Greenhouse, *Podiatrists to Form Nationwide Union: A Reply to HMOs,* NEW YORK TIMES, Oct. 25, 1996, at A6.

66. In contrast, networks that are paid on a "risk" basis accept capitation, percentage of premium, fee withholds, or other arrangements that put the network at financial risk for the use of health care services by beneficiaries of the health plan.

cians organize such a network and agree on fees to charge payers who contract with the network, or if they authorize one person to negotiate fees with payers on behalf of the physicians in the network, they have engaged in price fixing that is illegal per se under federal antitrust laws.[67]

However, Statement Nine describes a way to organize a simple network that is legal. It involves the use of the messenger model. This model allows a simple network to arrive at fee arrangements with payers and to dialogue with payers about nonfee-related issues, such as the medical policy of the health plan and the administrative procedures for hospital admission preauthorization.

1. How the Messenger Model Works

The object of the messenger model is to allow a simple network to operate without the existence of a fee agreement among the participating physicians. This means that the network physicians cannot communicate with each other to agree on a fee schedule. Further, even in the absence of such an agreement, the physicians cannot agree to abide by a fee schedule negotiated on their behalf by an agent of the network. The messenger model allows the physicians to appoint a "messenger" who facilitates the development of a fee schedule between payers and each physician in the network. The process works as follows.

The messenger communicates with each physician individually about what fee range the physician is willing to accept. The communications may be handled by telephone, mail, or personal meetings. The messenger may not inform any physician about the fee ranges that are acceptable to other physicians in the network, and the physicians may not communicate among themselves about fees that are acceptable to them.

Each physician may give the messenger authority to accept contracts from payers that are within the limits of the fee range that the physician is willing to accept.[68] One of the variations on

67. Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982).

68. The 1993 Statements did not expressly authorize the use of the messenger model. The 1994 Statements authorized the use of the messenger model, but did not expressly authorize physicians to preauthorize the messenger to accept offers from payers. As a result, all offers made by payers had to be communicated to physicians individually, and each physician had to make a unilateral decision about whether to accept an offer. 1994 STATEMENTS, *supra* note 3, at 94-96. This made messenger models cumbersome, time consuming, and expensive to operate. Jack R. Bierig, *Physician-Sponsored Managed Care Networks: Two Suggestions for Antitrust Reform*, 6

this authority is that the physician may authorize the messenger to accept contracts with fees equal to or better than fees provided in a contract already accepted by the physician.

The messenger may aggregate the information obtained from each individual physician. In doing so, the messenger may develop a schedule showing what percentage of physicians in the network would accept offers at various fee levels. Again, the messenger may not share this information with the physicians.[69]

The messenger then presents the schedules to payers and solicits offers. Any payer may then make an offer to the physicians in the network. The offer is most likely to be in the form of a fee schedule. If the messenger negotiates with the payer over the offers, the process then constitutes a potential illegal price-fixing arrangement.

The messenger may accept the offer on behalf of any physician who has given the messenger authority to accept offers within the fee range offered by the payer. The messenger may also accept on behalf of a physician an offer that is better than an offer previously accepted by that physician.

Any offer that is not within the fee range authorized by a physician must be forwarded to that physician for acceptance or rejection. The messenger may not exercise discretion about which offers to forward to physicians. For example, the messenger may not decide to forgo an offer because it is too low. The messenger may provide objective information to physicians in the network about a contract offer made to a payer, such as the meaning of terms and how the offer compares with offers made by other payers. However, the messenger may not give advice about whether to accept the offer, and may not inform physicians of those who have accepted or rejected the offer. Finally, physicians in the network may not communicate with each other about whether to accept a given offer.

2. Additional Features that Can Be Included in a Messenger Model Network

This process appears to be cumbersome, but it can work very smoothly, especially if the physicians are willing to preauthorize acceptance of competitive fees that are likely to be offered by

HEALTH MATRIX 115, 122 (1996). The addition of preauthorization can significantly enhance the efficiency of a network.

69. This feature, not contained within the 1994 Statements, makes the messenger model more efficient to operate.

payers. One problem facing a messenger model network is how to arrive at a competitive fee schedule given that the physicians are not allowed to communicate with each other and reach agreements about fee levels. A solution is found in Statements Five and Six, which allow the network to take a survey of physician fees and costs in the market, and to share that survey with the physicians if the survey meets certain criteria. The survey may also be provided to payers.

Physicians may use the survey information to decide at what rate they want to set their fees. Obviously, each participating physician has to decide whether to price at a competitive level. Some may decide to price above the market, and those who find that they are already below average market levels may decide to increase their fees. However, those physicians who decide to price above competitive levels are not likely to receive any offers at that level. The survey will demonstrate why they are not getting business, and they will have an informed basis upon which to change their pricing strategy.

If done within the limits set forth in the Statements, development and dissemination of a survey to physicians in a network will qualify for an antitrust safety zone. Statement Six sets the criteria for the safety zone:

> (1) [The collection of survey data] is managed by a third party, [such as] a purchaser, government agency, health care consultant, academic institution, or trade association;
>
> (2) The information provided by survey participants is based on data more than 3 months old; and
>
> (3) . . . at least five providers report[ed] data [for each statistic in the survey,] no individual provider's data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.[70]

The requirement that the data be more than three months old is especially important. If the fees surveyed are less than three months old, or if they contain current fees or future fees that physicians intend to charge, the agencies are likely to consider the provision of the survey information to physicians as anticompetitive.[71]

70. STATEMENTS, *supra* note 1, at 50.

71. The simple act of providing such information to physicians is not in itself a violation of the antitrust laws. Illegal price fixing will occur if the physicians then use that information to price above competitive levels in the market. A violation can

However, Statement Five sets forth a safety zone that allows providers to furnish a survey of current fees and costs to payers. The Statement requires that a survey of current fees or costs furnished to payers must be taken by a third party, as described above, to qualify for the safety zone. The messenger may wish to share the survey with the payers to show that the fees being offered by participating physicians are competitive with market levels or are not out of proportion to the costs faced by the physicians.

Furnishing a survey of future fee-related information to payers is not included in the safety zone. According to Statement Five, in some circumstances such information might be useful to a purchaser. Statement Five warns that the collective provision of future fee-related information may evidence or facilitate a price-fixing agreement, or it may exert a coercive effect on purchasers by implying or threatening a boycott if the payer does not agree to the terms being proposed. If future fee-related information is provided to purchasers, it should be gathered and presented pursuant to the safety zone procedures.

3. Dialogue Over Medical Policy and Non-Fee-Related Administrative Issues

Statement Four creates a safety zone available to simple networks that wish to collectively gather and present medical data to payers for the purpose of providing input into the payer's medical policies. Such data should be directed at improving the payers' resolution of issues relating to the mode, quality, or efficiency of treatment. The safety zone includes the gathering of outcomes data and the provision of these data to purchasers as well as the development of practice parameters and the presentation of these practice parameters to payers.

Physicians in the network can meet and discuss the medical data, the information that should be provided to a payer, and the physicians' positions about what constitutes good medical policy. Representatives of the network may, acting on behalf of the physicians in the network, have a dialogue with payers about the implications of the data and practice parameters presented.

occur even if there is no express agreement among the physicians to coordinate their prices. The communication of the information together with subsequent pricing above competitive levels will constitute the conspiracy. Using data that is more than three months old is allowed because it does not necessarily reflect the current charges of physicians.

However, the physicians in the network may not collectively threaten or actually boycott providers who refuse to adopt the positions advocated by the network.

The safety zone does not include the collective provision of other types of non-fee-related data to health plans by providers. However, the provision of non-fee-related data to a payer in an effort to influence how the payer deals with providers does not necessarily cause antitrust concerns. Therefore, the Statements allow a network to gather and present non-fee-related data on other topics, such as ways to improve the health plan administrative processes that affect the efficiency of the physician's practice. For example, the network can present a procedure for verification of benefits and preauthorization of hospital admissions.

4. Size Limits for the Messenger Model

Finally, messenger model networks can include large numbers of physicians in a market because they are not reaching agreements with each other on fee schedules. This enables messenger models to be very marketable to payers who want to have unrestricted access to a large panel of physicians. In addition, a messenger model need not exclude physicians within a community.[72] When physicians are just starting down the road of network organization, they are often not prepared to organize networks with limited participation. They are concerned that such networks would cause bitterness and lack of trust among the physicians. Therefore, they want the network to be highly inclusive. This step may be necessary for a medical community to adapt to managed care without disruption.

B. *Fee-for-Service Networks with Clinical Integration*

As with simple networks, there is a need for fee-for-service networks. Some physicians are willing and able to organize a network that is capable of more than a simple network, but they are not ready to enter risk-sharing arrangements such as a capitated agreement. Alternatively, the payers in the market may not want to share risk because their beneficiaries may not want to accept the restrictions on choice that often accompany capitation arrangements. In addition, self-funded employers may want to directly contract with a network, but do not want to

72. For example, Hypothetical Seven to Statement Eight describes with approval a messenger model that includes all of the physicians in a small, rural county.

share risk because the network would then be exposed to insurance regulation. It is expensive and time consuming to obtain and maintain an insurance license, creating costs that must be passed on to the employer. In addition, the regulations can affect the design of the employer's benefits program because holders of insurance licenses must comply with state laws mandating coverage of various health care services.

Therefore, networks and payers, especially self-funded employers, may find it more advantageous to operate on a fee-for-service basis. These networks may be willing and able to include features designed to reduce the employer's cost and enhance quality, such as physician credentialing, utilization review, quality assurance, and perhaps other activities. However, as stated earlier, a network of physicians who agree on the fees to charge through the network may be engaged in price fixing that is illegal per se, unless it can fit within an exception to the per se rule.

1. Exception From the Per Se Rule for Fee-for-Service Networks that Do Not Share Risk

The Statements allow a fee-for-service network to be analyzed under the rule of reason if it possesses adequate "clinical integration" sufficient to demonstrate that (1) the network *is likely* to produce significant efficiencies that benefit consumers, and (2) any price agreements or other restraints that are ordinarily illegal per se among network physicians are reasonably necessary to achieve the efficiencies. It is important to note that the standard set forth by Statement Eight for proof of efficiencies to *qualify* for rule of reason analysis is one of *likelihood*—the efficiencies need not be proven as an absolute fact.

The problem that physicians and attorneys have in applying this Statement is knowing when sufficient clinical integration exists to qualify for and pass a rule of reason analysis. To determine this, it is necessary to understand what activities constitute clinical integration.

2. Techniques Sufficient to Constitute Clinical Integration

Statement Eight states that clinical integration "can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the networks' [sic] physician participants and create a high degree of interde-

pendence and cooperation among the physicians to control costs and ensure quality."[73] Such a program may include:

> (1) . . . [M]echanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care;
>
> (2) [The choice of] network physicians who are likely to further these efficiency objectives; and
>
> (3) [T]he significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.[74]

This description rules out networks that do no more than achieve transactional efficiencies, such as arranging for broad geographic and specialty coverage at discounted prices. Transactional efficiencies reduce costs, but are insufficient to affect the nature and cost, or overall value, of the health care services delivered by the network. The addition of administrative services such as claims payment is not sufficient either. The agencies recognize that transactional and administrative efficiencies have value, but do not believe that the value outweighs the anticompetitive effects of allowing the physicians in the network to agree on fee levels. This conclusion is in keeping with the agencies' views of transactional efficiencies in joint ventures generally—they are not considered adequate to justify horizontal price agreements among the participants.[75] Networks that rely on transactional efficiencies must use the messenger model to arrive at price arrangements with payers. Equally, the addition of physician credentialing does not suffice. Credentialing establishes the qualifications of physicians, such as their training and disciplinary and malpractice experience, but it does not do enough to affect the overall value of the medical care delivered.

A network that implements transactional and administrative efficiencies, physician credentialing, and preauthorization of hospital admissions moves into a gray area—it is uncertain whether the agencies would allow it to be evaluated under the rule of reason. Such a network would be too similar to the network found to be per se illegal in *Arizona v. Maricopa County Medical Society*.[76] Although the preauthorization feature of the

73. STATEMENTS, *supra* note 1, at 72.
74. *Id.* at 72-73.
75. However, not all commentators and perhaps not all courts agree with the agencies on this subject. *See, e.g.*, BORK, *supra* note 21 (arguing that a joint venture offering transactional efficiencies only should be evaluated by the rule of reason).
76. 457 U.S. 332 (1982).

network amounts to utilization review, Statement Eight seems to require more. It says that the process should involve a monitoring of the practice patterns of individual physicians that leads to a change in their practice patterns to achieve efficiencies. It should also foster the selection of physicians who further these efficiency goals. Inclusion of retrospective and concurrent review would probably lead to the same conclusion.

However, if the utilization review features are carried out effectively, the network will be able to deliver a material amount of efficiencies. It is well established that the use of an effective preauthorization program by itself provides significant cost savings.[77] In addition, the effective use of utilization review does affect physician practice patterns. Even if physicians are not individually monitored, they learn the conditions under which the reviewer is likely to deny coverage for care, and should adjust their practices accordingly. There are likely to be payers who want to negotiate price arrangements with a fee-for-service network that can deliver these efficiencies. As a result, courts may find that such a network should be evaluated under the rule of reason; learned commentators may well agree. While the agencies may be reluctant to affirmatively state that such a network will qualify for rule of reason analysis, if the network in fact delivers these efficiencies and does not engage in anticompetitive conduct, it may well be legal.

A feature that may help tip the balance for networks that have the above characteristics is the adoption or development of practice guidelines for use by physicians in the network. However, the physicians in the network must apply the practice guidelines when treating patients, and the guidelines should be consistent with the protocols applied through the utilization review process. If the guidelines are not used or if they are not consistent with utilization review procedures, they will not generate efficiencies.

The use of practice guidelines may help qualify a network for rule of reason analysis because it reflects an effort to have all of the network physicians follow a best practice. This use, coupled with a utilization review process targeted at criteria that are con-

77. Memorandum from Verdon S. Staines to Congressional Budget Office Staff, The Potential Impact of Certain Forms of Managed Care on Health Care Expenditures 6-7, 19 (Aug., 1992) (on file with the author). *See also* DAVID C. STAPLETON, NEW EVIDENCE ON SAVINGS FROM NETWORK MODELS OF MANAGED CARE, LEWIN-VHI, INC. REPORT TO THE HEALTHCARE LEADERSHIP COUNCIL (May 5, 1994).

Annals of Health Law, Vol. 6 [1997], Iss. 1, Art. 3

sistent with the guidelines, shows that the network is clearly coordinating the care of the physicians to achieve higher quality and/or lower costs, thereby attempting to distinguish itself from competitors by developing and applying its own concepts about how to deliver a good value to patients. Again, even if a network with all of the above characteristics does not monitor individual physicians, it can coordinate[78] care and secure material efficiencies.

Once a network combines physician practice pattern profiles, transactional and administrative efficiencies, credentialing, preauthorization and other utilization review procedures, and practice guidelines, it should clearly be comprised of sufficient clinical integration under the Statements. However, the profiling should be used to educate physicians in the network about how to achieve high-quality, cost-effective care and to terminate physicians who are persistent overutilizers. Once that dimension is added, the physicians in the network are actively working with each other to change the nature of the health care they are delivering. It squarely meets the description of clinical integration in Statement Eight—the network is implementing "an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and [to] create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[79]

A network that implements all of the above features and engages in total quality improvement ("TQI")[80] even more clearly evidences clinical integration. TQI involves the gathering of data about the total cost of physician performance for treatment of a given illness or injury and the analyzing of the variations in cost and outcome. The object is to determine the most effective process for treating patients for a particular problem, and then to reduce the variation from that optimal physician performance. It requires that physicians work together to analyze the data sufficiently to enable them to reliably explain the variations in performance, and then to develop a protocol for the optimal

78. The addition of primary care physicians as gatekeepers to networks with the above features would add a degree of explicit coordination among the physicians in the actual handling of patients. However, gatekeepers are rarely used in a fee-for-service network where there is no risk sharing among the physicians. One of the most important attributes of fee-for-service networks is a wide choice of physicians for the patients. Use of gatekeepers is not compatible with that attribute.

79. STATEMENTS, *supra* note 1, at 72.

80. *See supra* note 57.

process for treating a problem. When the network uses TQI, the physicians coordinate at a high level their efforts to reduce costs and assure high quality.

Such a network also meets the description of a fee-for-service network in Hypothetical One at the end of Statement Eight, which network was deemed by the agencies to have adequate clinical integration. This hypothetical network maintained systems to establish goals relating to quality and appropriate utilization of services by network participants, it regularly evaluated both the physician participants' individual performance and the network's aggregate performance with respect to those goals, where necessary it modified the physicians' actual practices based on those evaluations, it engaged in case management, preauthorization of some services, and concurrent and retrospective review of inpatient stays, it developed practice standards and protocols to govern treatment and utilization of services, and it planned to actively review the care rendered by each physician in light of these standards and protocols. The hypothetical network was organized around a core of primary care physicians and included specialists who were selected based on their established referral relationships with the primary care physicians as well as their willingness to cooperate with the goals of the network and the need to provide convenient services to beneficiaries. Network physicians who failed to adhere to the network's standards and protocols were subject to remedial action, including expulsion if necessary. Hypothetical One at the end of Statement Nine describes a physician hospital organization with a similar degree of clinical integration.

3. The Cost of Clinical Integration

As a network proceeds from transactional efficiencies to TQI, the administrative work necessary to carry out the functions and the potential costs of the operation increase. While it is possible to invest many millions of dollars in electronic data gathering and analysis systems, as some claim is necessary to achieve clinical integration, it is also possible to achieve the required clinical integration through more modest efforts.

The perceptions of attorneys who believe that multimillion dollar investments are necessary may be based on Hypothetical One at the end of Statement Eight. The hypothetical network described with approval made a significant investment of capital, purchasing information systems necessary to gather aggre-

Annals of Health Law, Vol. 6 [1997], Iss. 1, Art. 3

gate and individual data on the cost, quantity, and nature of services provided or ordered by the network physicians, to measure the performance of the group and the individual physicians against cost and quality benchmarks, and to monitor patient satisfaction. In addition, the hypothetical network hired a medical director and support staff to perform these functions and to coordinate patient care in specific cases.

However, the agencies should not require that multimillion dollar investments be in place before a fee-for-service network is considered to be clinically integrated. It does not promote the efficient performance of participants in a market to demand that they invest large sums of money if such investments are not necessary to achieve the efficiencies that will benefit the market. This would simply add costs to an industry that is already struggling to become more efficient. In addition, it is unrealistic to expect a start-up fee-for-service network to have expensive management assets in place before it has any payer contracts. The network would have substantial overhead expenses with too few patients. This would simply assure large losses for a long period of time.

Instead, the investment in management assets should be in proportion to the expected volume of the network. In addition, the network should be able to rely on vendors, such as service bureaus, hospitals, and payers with an interest in the success of the network to provide much of the management capacity necessary. Application of this capacity to develop efficiencies should be handled by physicians in the network.

Service bureaus can be retained to handle many of the administrative aspects of a network.[81] They can also handle preauthorization and other types of utilization review. This may be the most cost-effective way to handle these elements of a new network, as it is not likely to have enough patient volume to justify hiring an administrative staff. A service bureau's staff can provide services on a part-time basis. Committees of physicians in the network can review the protocols used by the service bureau to make utilization review decisions, and they can review how the utilization review process is affecting the quality

81. For a simple article that explains whether to invest in an information system for these administrative systems or hire a service bureau to handle them, see Peg Costandino, *Technical Considerations for Building or Outsourcing Information Systems for Managed Care Applications*, HEALTH CARE INNOVATIONS, July\Aug. 1996, at 6.

of care delivered by the network. As the network grows, it can gradually assume the administrative and utilization review functions itself.

Practice guidelines are available from numerous sources, including medical societies, government agencies, hospitals, payers, and think tanks.[82] The network can form committees of participating physicians to consider what practice guidelines to adopt, and the committee can decide to modify a guideline from another source prior to adopting it. Physician committees can also draft their own guidelines based on data and studies available in the medical literature and their own experiences.

Data on the performance of individual physicians are necessary to engage in profiling. Given that the network operates on a fee-for-service basis, these can be assembled from claims data. However, the network does not have to assemble the data and create the profiles itself. Service bureaus, payers, or hospitals can perform these functions. Payers in particular are interested in the network improving its performance, generally have the ability to assemble claims data, and may be willing to assemble the profiling data and provide them to the network. Hospitals may have an interest in the success of the physicians who patronize them.

Further, the profiles do not have to be for every type of service provided by each physician in the network. It is more effective to target a small number of high-volume services that account for a disproportionate amount of the claims and review physician performance in handling those services. Limiting the focus reduces the amount of data that must be gathered and the cost of assembling the data into profiles. The data review can be handled by a committee of participating physicians who work with other physicians in the network to improve their performance.

Data and analysis for TQI can be handled in a similar way. A service bureau, payer, or hospital can assemble the data. A hospital may be willing to assemble data if the procedures at issue are performed on its premises and involve the manner in which the physicians will direct the hospital staff in the care of the patients. The participating physicians can then analyze the data to gain a better understanding of the reasons for variation in cost

82. The American Medical Association publishes a directory that lists 1800 practice guidelines developed by 70 physician organizations and other groups. AMERICAN MED. ASS'N, DIRECTORY OF PRACTICE PARAMETERS (1996).

and outcome and can develop protocols to reduce variation around a desired quality outcome and cost.

4. The Amount of Physician Investment

Statement Eight also requires that physicians invest significant capital, both monetary and human, in the necessary infrastructure and the capability to realize the claimed efficiencies. The purpose of this requirement is to assure that the network is not a sham and that the physicians involved have a stake in the success of the network as an enterprise. The agencies assume that if the physicians do not have a stake in its success, the efficiencies might not be achieved, and the network might be used as a vehicle to coordinate fees among the physicians. This requirement raises the question of how much the network physicians must invest both in the aggregate and on a per-physician basis to qualify for rule of reason treatment.

The answer to the first question is based upon the discussion above. The aggregate size of the investment should be in proportion to the expected volume of the network and the cost of establishing the functions it needs to realize efficiencies. No arbitrary amount of investment should be required. It should be recognized that a network that finds ways to minimize the investment necessary to carry out the functions that achieve the efficiencies is performing well. If this can be done by leasing functions from vendors or receiving contributed functions from interested parties or equity or contract partners, this should be allowed. The key requirement for rule of reason qualification is that the efficiency-enhancing functions are in place and are functioning to achieve the desired efficiencies.

Likewise, there should be no arbitrary amount of money or time required for a per-physician investment. It should be sufficient to give the physicians involved a stake in the success of the network as an ongoing enterprise so that they will work to achieve efficiencies. It may be that a core group of physicians who do most of the work to organize the network have larger investments than others. This should be sufficient, as it motivates the core group to get the management systems in place that are necessary for the network to be successful.

C. *Network Percentage Specialty Limits*

An important issue is what percentage of specialty limits[83] will apply when a network is evaluated under the rule of reason. This is a critical issue because a network with a large enough percentage of the physicians in the market may be able to exercise market power, controlling the levels of output and fees. However, having a large percentage of physicians in a market is also an important network attribute because purchasers want to have access to a wide choice of physicians. This is especially important for fee-for-service networks that rely on unrestricted access to a wide choice of physicians as a way to differentiate themselves from capitated networks that may be lower in cost but that restrict choice.[84] Therefore, it becomes important to balance concerns about market power against the competitive realities faced by the network.

According to Statement Eight,

> merely because a physician network joint venture does not come within a safety zone in no way indicates that it is unlawful under the antitrust laws. On the contrary, such arrangements may be procompetitive and lawful, and many such arrangements have received favorable business review letters or advisory opinions from the agencies.[85]

The Statements then list in a footnote networks approved by the DOJ or FTC that accounted for a percentage of given specialties ranging from thirty to fifty percent of the available physicians. The Statements continue: "[P]hysician network joint ventures in which the physicians share substantial financial risk, but which involve a higher percentage of physicians in a relevant market than specified in the safety zones, may be lawful if they

83. *See supra* section II.

84. In recent years, choice has become an even more important factor as the public became concerned about the quality of care available under health plans. *See, e.g., The Health Care Revolution—Remaking Medicine in California*, L.A. TIMES (14 stories appearing from August 27-31, 1995, reporting the results of a 14-month investigation into managed care); *HMOs—What You Don't Know Can Kill You*, N.Y. POST (six stories appearing from September 18-20, 1995); Ellyn E. Spragins, *Beware Your HMO*, NEWSWEEK, Oct. 23, 1995, at 54; Erik Larson, *The Soul of an HMO*, TIME, Jan. 22, 1996, at 44; *CBS Evening News With Dan Rather: Eye On America Series on Health Maintenance Organizations* (CBS television broadcast, July 24-26, 1995). Without reliable information to compare health plan performance, patients rely on choice as a proxy for quality.

85. STATEMENTS, *supra* note 1, at 63.

are not anticompetitive on balance."[86] While this clarifies that the agencies may allow such networks, no specific guidance is provided about maximum percentage limits that will be allowed, and it does not appear that the agencies have any maximum percentage limits. Instead, they will determine whether a network is lawful based on the interaction of a variety of factors, including market power. This makes it difficult to predict with precision the reaction of the agencies to a network with greater concentration percentages than permitted by the safety zone.

The Statements provide several sets of criteria to consider in evaluating market power, once the concentration of the network has been determined. These criteria are discussed below.

(1) *Exclusive Versus Nonexclusive Networks.* Exclusive networks pose a greater danger to competition than nonexclusive networks because the physicians in an exclusive network are not able to join competing networks or to contract with health plans that have not contracted with the network. In this regard, Statement Eight sets forth five criteria for what constitutes a nonexclusive network.[87]

(A) Whether "viable competing networks or managed care plans with adequate physician participation currently exist in the market . . . ." If there are no other networks, or if there are no managed care plans in the market that have panels of physicians other than the network, then the agencies may suspect that the network is not truly nonexclusive.

(B) Whether the "physicians in the network actually individually participate in, or contract with, other networks or managed care plans, or [whether] there is other evidence of their willingness and incentive to do so . . . ." If the network physicians do not contract with other networks or plans, and there is evidence that they are not inclined to do so, then the network may not be truly nonexclusive.

(C) Whether "physicians in the network earn substantial revenue from other networks or through individual contracts with managed care plans . . . ." If most of the managed care revenue earned by network physicians comes from

86. STATEMENTS, *supra* note 1, at 70 n.24; *see also* Hypotheticals Five and Six at the end of Statement Eight (describing with approval networks that are substantially larger than the safety zone limits).

87. The indicia of nonexclusivity are set forth at STATEMENTS, *supra* note 1, at 66-67.

the network, and not from other networks or managed care plans, the network may be deemed exclusive.

(D) Whether there are "any indications of significant departicipation from other networks or managed care plans in the market . . . ." If the physicians who formed the network have dropped out of other networks or managed care plans, then the network might not be truly nonexclusive.

(E) Whether there are "any indications of coordination among the physicians in the network regarding price or other competitively significant terms of participation in other networks or managed care plans." If so, then the network might not be truly nonexclusive even if the physicians participate in and derive significant amounts of revenue from other networks or managed care plans, as the physicians are using the network to arrive at terms of dealing that they will demand from all payers.

(2) *The Availability of Competing Networks.* Even if a network is nonexclusive, a large network may have market power if there are not many other managed care alternatives. If there are many other options for managed care plans, then it is unlikely that a large network would raise significant competitive concerns.

(3) *The Degree of Competition Facing the Network.* The greater the competition, the more likely the network will actually realize efficiencies and the less likely it is able to exercise market power. In assessing the competitive environment, the agencies consider factors such as the number, types, and sizes of managed care plans operating in the area, the extent of physician participation in those plans, and the economic importance of the managed care plans to area physicians.

(4) *The Extent to Which Different Groups of Physicians in the Network Have Divergent Financial Interests.* It is possible that within a network, a small set of "owner" physicians may have made a larger investment in the network while "contractor" physicians may have made no investment at all. The owner physicians control and operate the network and have an incentive to have the network be competitive and successful. The owner physicians may want the network to contract with the contractor physicians on the best possible terms so that the network can be competitive in the market. Therefore, the interests of the owner and contractor physicians diverge in a way that may prevent

them from joining in anticompetitive conduct. Under these conditions, it may be possible for a network to be very large,[88] as the motive of the owner physicians will be to offer a wide choice of physicians to payers, yet not possess market power.

(5) *Minimal Possibility of "Spillover" Effects.* Spillover effects occur when the physicians in a network exchange competitive information to fix prices, divide markets, or engage in other restraints when dealing with payers outside of the network. Spillover can be minimized by setting up structures designed to minimize the exchange of competitive information among physicians in the network, such as fees. For example, the network may set a fee schedule based upon an agreement by the physicians to accept the fees negotiated on their behalf by the network, as opposed to having the physicians meet and agree on a fee schedule to offer. When a network is very large, and the physicians meet and agree on a fee schedule, there is risk that the physicians will use that fee schedule as a benchmark for their dealings with other networks and for individual participation in managed care plans. This can occur even without the knowledge or intent of the network management.

Spillover effects can also occur when a large network is successful and accounts for a significant portion of the revenues of physicians in the market. The physicians may start to look to the network for guidance in deciding with which managed care plans to deal, simply because it is easier than considering the merits of each managed care plan that is offered to them. As a result, physicians in the network may start to turn down con-

88. *See* Final Judgment and Competitive Impact Statement, United States v. Health Choice of Northwest Mo., Inc., Civil Action No. 95-6171-CV-SJ-6 (W.D. Mo. Sept. 9, 1995); Final Judgment and Competitive Impact Statement, United States v. Healthcare Partners, Inc., Civil Action No. 395-CV-01946RNC (D. Conn. Sept. 9, 1995). These consent decrees set forth the manner in which the networks involved could be structured using divergent financial interests. For example, a "qualified managed care plan" approved in the consent decrees involved networks of physicians some of whom had significant ownership interests and therefore had an incentive to see the network succeed. They had a motive to bargain with noninvestor physicians who contracted to deliver services through the network to obtain their services as cheaply as possible. By way of further example, many IPAs negotiate financial arrangements with payers on behalf of primary care physicians that gives them an incentive to make minimal use of specialist services. The same IPA negotiates fee schedules with the same payers on behalf of the specialists. There creates an economic tension between the primary care physicians, who want the specialist care to be as inexpensive as possible, and the specialists. Under the circumstances of either example, price-fixing conspiracies are unlikely, even though the IPA is negotiating fees on behalf of specialist physicians. These consent decrees are referred to with approval at STATEMENTS, *supra* note 1, at 78 n.39.

tracts from payers who have not contracted with the network or may ask that managed care plans negotiate with the network rather than with them individually. This can cause a large network to become exclusive, even though this result is not intended by the network managers.

(6) *Rural Settings.* It may not be possible to have anything but a large network in rural settings where there are not enough providers to form more than one network. The agencies recognize this and are willing to allow such networks if there are sufficient safeguards to prevent anticompetitive conduct. Hypotheticals Five and Six at the end of Statement Eight describe such networks.

(7) *Payer Reaction.* Payers such as health plans may want access to a large network of providers. This is most likely to occur if the payer is trying to enter a market or wants to be able to offer a wide choice of providers, an attribute frequently desired by beneficiaries. Positive payer reaction to the formation of a network will favor its being found legal.[89]

In some cases, the determination of whether a network has an impermissible amount of market power will be obvious upon a superficial review of the market. Other cases will require a more detailed analysis. A large network that is likely to survive a rule of reason analysis is one that has divergent financial interests and procedures to minimize the possibility of spillover effects. Another type of large network likely to survive is one that is nonexclusive, operates in a competitive market where there are a number of health plans that have no problems obtaining physicians to participate on their panels, has procedures to guard against spillover, and is sought by payers.

D. *Direct Contracting with Risk Pool Incentives Without an Insurance License*

Direct contracting between networks and self-funded employers[90] is an opportunity that has drawn a great deal of interest from networks and employers alike. Since the benefit plans of these employers are exempt from state insurance regulation

89. Hypotheticals Five and Six at the end of Statement Eight provide examples of payers who wanted a large network to be formed.

90. Self-funded employers are those who do not purchase insurance to fund their employee health benefits plans; instead they pay for health benefits plans themselves. For a more detailed description, see *supra* note 14.

under ERISA,[91] self-funded employers do not have to incur the cost of complying with state regulations, including paying premium taxes, meeting solvency standards, providing mandated benefits, and offering community-rated premiums.[92] These costs are significant, and employers have been able to save substantial amounts by becoming self funded. They may also be able to achieve savings by eliminating the profit margin of insurers. However, most self-funded plans are administered by insurers because employers do not have the capacity to administer their benefits plans. Since insurers profit on the administration of plans, it is uncertain whether self-funding results in savings above those achieved by avoiding state regulation. However, the insurer administering a self-funded plan can implement cost-saving managed care techniques; it can contract with physicians to serve the self-funded plan, obtain discounts, and secure agreements to participate in utilization review programs operated by the insurer on behalf of the employer.

Direct contracting occurs when a network (organized by physicians as opposed to an insurer) contracts with a self-funded employer to deliver health care that will be needed by the employees who are covered by the employer. Self-funded employers are interested in contracting with networks to obtain access to cost-effective health care without having to organize and administer their own networks of physicians. Physicians have become interested in direct contracting because it provides them with more autonomy over patient care and the economics of their medical practice.

Most self-funded employee benefit plans are fee-for-service options—that is, indemnity plans or preferred provider organizations. Until the Statements were issued, it was legally perilous for networks to engage in direct contracting on a fee-for-service basis unless the physicians arrived at fee arrangements using the messenger model. Arrangements between the physicians and employees for agreed-upon discounted fees were likely to be categorized as illegal price-fixing arrangements. Now, Statement Eight enables networks to engage in direct contracting on a fee-for-service basis because it allows for the messenger model as well as clinically integrated fee-for-service networks.

91. 29 U.S.C. § 1144 (1994).

92. Licensed insurers bear these costs directly when an employer purchases insurance, but then pass these costs on to the employers, their customers.

Health maintenance organization ("HMO") options offered by employers are generally not self-funded. Instead, they are underwritten by state-licensed HMOs, and the cost of complying with state regulations is passed on to the employers. In recent years, employers have become more interested in directly contracting with physicians on a risk-sharing basis, such as through capitation. This would enable the employer to avoid the cost of HMO state regulation.

However, a network that engages in risk sharing with an employer by entering into capitation arrangements without obtaining a state insurance license may run afoul of states' insurance laws. Most states have concluded that the act of offering capitation to an employer constitutes the business of insurance.[93] State insurance commissioners argue that capitation involves the sharing and spreading of risk, which is the essence of what constitutes an insurance arrangement subject to state regulation.[94]

However, the agencies created a safety zone, providing an opportunity for networks to engage in direct contracting in a way that allows them to share in the rewards of achieving savings in risk pools and to reap the benefits of a global capitation arrangement with an employer without obtaining an insurance license. To do this, the Statements establish the following category of substantial financial risk:

> [U]se by the venture of significant financial incentives for its physician participants, as a group, to achieve specified cost-containment goals . . . [including] . . . establishing overall cost or utilization targets for the network as a whole, with the network's physician participants subject to subsequent substantial rewards or penalties based on group performance in meeting the targets . . . .[95]

93. Most state insurance commissioners require that provider networks that share risk directly with a self-funded employer obtain an insurance license. Overbay & Hall, *supra* note 16, at 364. *See also* Shipley, *supra* note 16. There are some exceptions. For example, the State of Illinois does not require a license if the employer continues to assume ultimate responsibility for providing the benefits to employees in the event that the provider group becomes insolvent. DAVID GRANT, ILLINOIS DEP'T OF INS., PROVIDER BASED MARKET SYSTEMS: WHEN TO REGULATE (1996). The attorney general of North Carolina has rendered an opinion agreeing with Illinois. Durham County Hosp. Corp., Advisory Opinion: Contracting with Self-Insured Employee Benefit Plans and Health Care Providers (written by Jenn R. McArthur, Chief Counsel, & Andrew A. Vanore, Jr. to John L. Crill) (Oct. 9, 1996) (on file with the author).

94. Overbay & Hall, *supra* note 16, at 369-74.

95. STATEMENTS, *supra* note 1, at 69.

Annals of Health Law, Vol. 6 [1997], Iss. 1, Art. 3

The Statements do not clearly express whether a network would be subject to substantial financial risk sharing, and therefore fall within the safety zone, if it provides rewards but does not impose penalties. However, under the logic of this defined category of substantial financial risk, the arrangement should qualify for a safety zone if the bonus is substantial enough to provide a significant financial incentive for the physicians to achieve the specified cost-containment goals. Use of the reward-only arrangement should prevent the network from being categorized as an insurer by a state insurance commissioner because there is no downside risk that is being underwritten by the network that could cause insolvency if not appropriately managed.[96]

The arrangement could work in the following way. All of the physicians could agree to a discounted fee schedule whereby their usual fees would be discounted by an average of twenty-five percent. The physicians would also agree to predetermined budgets with a payer based upon the payer's historical experience. The budget would be broken down into several components, including a physician component, a hospital component, and a pharmaceutical component. If the physicians meet the aggregate budget, they would be entitled to a bonus of ten percent of their fees. If they would come in below any budget, they would get a bonus of fifty percent of the savings. If they would beat some budgets but come over budget on others, the amount saved would be offset by the amount overspent. The physicians would substantially invest in and donate time to the operation of a utilization and quality control system that could enable them to manage costs sufficiently to qualify for the bonus.

The arrangement described above should fall within the definition of substantial financial risk set forth in Statement Eight. To fall within a safety zone, the network must also meet the applicable specialty percentage size limits. This type of arrangement would fall within a safety zone because it is assumed that the physicians in the network must be clinically integrated and achieve efficiencies in order to reap the rewards, and it is assumed that these rewards give them an incentive to engage in clinical integration and in fact achieve the efficiencies.

96. There are limits to this argument. If, for example, a network agrees on fees that are so highly discounted that they must receive the reward in order to break even and make a profit, then the agreement is vulnerable to being categorized as an insurance arrangement.

Commentators believe that this type of arrangement is the key to achieving the ultimate promise of managed care. This promise boasts of significantly enhancing the quality of medicine while simultaneously reducing its cost by coordinating the efforts of multiple providers in the care of a patient. These commentators believe the promise can be achieved by networks that (1) use total quality improvement techniques to analyze both their outcomes and the resources used to achieve these outcomes, and (2) use the results of this analysis to develop protocols designed to achieve the best possible outcomes using the least possible resources.[97] Some believe that these techniques are most likely to be used successfully if implemented by networks that compete for the business of self-funded employers.[98]

CONCLUSION

The Statements provide significant opportunities for providers to form joint venture health care delivery networks. Interpretation of the Statements requires the exercise of judgment based upon a foundation of knowledge about joint venture analysis under federal antitrust laws. While the exercise of judgment lacks the type of precision that may make clients feel more comfortable, a well-informed attorney can provide opinions with a reasonable degree of confidence.

97. *See, e.g.*, Peter Boland, *The Role of Reengineering in Healthcare Delivery, in* REDESIGNING HEALTHCARE DELIVERY 3 (Peter Boland ed., 1996); WALTER A. ZELMAN, THE CHANGING HEALTH CARE MARKETPLACE 81-83 (1996).

98. For example, the Buyers Health Care Action Group ("BHCAG"), a buyers' coalition in Minneapolis, Minnesota, is experimenting with a direct contracting program where provider networks compete with each other for the business of the coalition. BHCAG is conducting the experiment because it believes that provider networks in competition with each other for the business of employers are most likely to realize the promise of managed care. Thomas Allen, *Applying Market Power—The BHCAG is Flexing its Muscle*, 77 MINN. MED. 6 (1994).